General Hospital Comments

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Nantucket Cottage Hospital
Nashoba Valley Medical Center
Newton-Wellesley Hospital
Noble Hospital
North Shore Medical Center – Salem
North Shore Medical Center – Union
Quincy Hospital
Saint Anne's Hospital
Saints Memorial Medical Center
South Shore Hospital
Southcoast Hospitals Group
Sturdy Memorial Hospital
Winchester Hospital

Anna Jaques Hospital

Review of reported cases reveals:

1. Duplicative data
2. Mortality rate is combined with patients from Subacute facility and the Acute facility at Anna Jaques Hospital

The inconsistency and inaccurate report raises relevant questions to the data being posted on the Public Web Site by the Department of Health & Human Services.

BI Deaconess Medical Center

At Beth Isreal Deaconess Medical Center, we strive for excellence in all aspects of patient care. We strongly support the growing movement to give patients information on quality, recognizing that measuring quality is not an easy undertaking. Patients using the information on this site should be reminded that there is no single perfect measure – they all have specific benefits and as well as specific limitations. We welcome the opportunity to have individual conversations with our patients at any time about the quality of care we deliver.

Brigham and Women's Hospital

Quality indicators: Many of the indicators within this report were developed by the Agency of Healthcare Research and Quality (AHRQ) with the intention that they be used to facilitate quality improvement and not be used to evaluate or compare hospitals. Brigham and Women's Hospital believes that the results

are not adjusted adequately for the acuity of our patients, and results for our hospital are therefore not comparable to the results of other Massachusetts hospitals on this website. Brigham and Women's Hospital encourages patients to evaluate many factors when selecting the hospital for their care: your doctor's recommendation, word of mouth from friends and family, and your own prior experiences of care in addition to the many sources of quality data on the world wide web.

Cost comparisons: Brigham and Women's Hospital has a three pronged mission of providing outstanding patient care, teaching doctors of the future, and developing new technologies and treatments, all of which are critical to providing our community with high quality care, now and in the future. Community hospitals do not invest as heavily as Academic Medical Centers in research and teaching and therefore tend to have lower costs (than Academic Medical Centers).

Brigham and Women's Hospital believes that the cost comparisons among hospitals in this report do not take into account certain factors affecting the cost of care among hospitals:

- Costs of Special Missions: Certain hospitals incur additional costs related to their societal missions of training physicians and other health professionals; devoting relatively large percentages of their care to indigent patients, and providing other substantial benefits to their communities.
- Severity and Complexity of Illness: Cost differences among hospitals may also be the result of differences in the average severity and complexity of illness of patients within an Indicator. For example, patients with more severe or complex cases of congestive heart failure (CHF) are more likely to seek care at teaching hospitals because of their teaching and research missions. Such patients require more intensive nursing care, more diagnostic tests and other resources.

These cost differences are formally recognized by Medicare, Massachusetts Medicaid and other payers in their determination of payment rates. Absent these adjustments, the cost of care among hospitals in this report may not be completely comparable. Users of this information are advised to consider this before drawing conclusions regarding the relative cost of care among hospitals.

Brockton Hospital

Brockton Hospital is fully supportive of the efforts of CMS and other organizations to provide meaningful information about hospital quality to the public. The public should keep in mind that these indicators represent a snapshot of where hospitals stood in FY03 and do not accurately reflect the quality of care one can expect to receive today at Brockton Hospital or any other facility.

Within the past year, as part of Brockton Hospital's ongoing quality improvement initiatives, we have developed and implemented many innovative programs and processes. These have now put us on the leading edge of quality not only for the CMS indicators, but also for many others.

Above all, patients should remember that these types of tools are still in their infancy and are not definitive indicators of hospital quality. Decisions about hospital care should be made primarily on the advice of your physician.

Caritas Carney Hospital

As requested members of the Caritas Christi Healthcare System have reviewed the materials submitted to our hospitals in the August 12th communication from EOHHS specific to the website release of hospital quality and cost data. We appreciate the opportunity to comment.

Most importantly, we support the intended activities of EOHHS to launch a public website to report comparative quality and cost data of acute care hospitals. This is indeed aligned with federal mandates to better inform the public of important activities of their local hospitals so as to provide the consumer with information to make an educated decision in selecting their healthcare as well as provide an incentive to the healthcare community to improve care. We do however have some concern with the information provided for possible publication and want to ensure the accuracy of this information before it is publicly

posted. We also feel it is important all stakeholders are in agreement with selection of quality measure sets that will support the intention of the informational website.

In order to review the reported quality and utilization data, we asked members of our information technology department to provide individual hospital reports of the twelve selected indicators for FY 2003 (October 1, 2002 thru September 30, 2003). We abstracted the information from the hospital discharge data using the exact parameters provided. As you are already aware, craniotomy data did not match at all. For most cases, number of deaths matched our reports except for Caritas Holy Family Medical Center Hospital hip replacement. Zero deaths are noted on our report whereas two (2) deaths are identified on the DHCFP report. All other denominators do not match as well as we note higher case numbers than reported. Obstetrical data for all six hospitals is a total mismatch and although we have been working DHCFP, we still cannot account for the disparity. Validation of this information should be a priority.

Secondly, we have concern with the use of AHRQ data to be the only indicator for quality. As noted on the AHRQ website, the access to AHRQ complication data should be used as a " *screening tool for hospital administrators to launch investigations into reasons for potential problems".* Administrative data continues to have limitations due to variability in coding, ambiguity in identification of condition pre-existence prior to hospital admission as well as limitations to availability of specific ICD-9-CM codes for all conditions. Although we review this data often, we note marked inaccuracies in acknowledging true issues with quality. For instance, Caritas St. Elizabeth's Medical Center reviews AHRQ data on a monthly basis. Post-operative/procedure pneumonias are reviewed. On average, we note 1 out of 3 cases actually meet the definition of pneumonia following surgical/procedural intervention, the others represent patients who arrive in the Emergency Department with suspect pneumonia, chest pain, have a cardiac intervention the next day. Of course these patients are additionally treated for the presenting pneumonia. The pneumonia did not follow the procedure but instead was also a condition on admission. As to using risk-adjusted mortality as an indicator of care, we remind you that the APR-DRG model for risk adjustment for mortality does not take into consideration transfer status nor DNR status, again, two important factors which impact patient's risk for mortality on admission to a hospital.

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Faulkner Hospital

Faulkner Hospital is committed to continuous quality improvement. Our expectation is that our ongoing efforts to improve patient quality and safety will be reflected in an efficient cost-effective environment. The Board, medical staff and employees of Faulkner Hospital are proud of our accomplishments to date and will continue to work to improve our patient care.

Hallmark Health System – Lawrence Memorial Hospital

Review of reported cases revealed:

1. Duplicate data for AMI cases;
2. Mortality for procedures not performed at Lawrence Memorial Hospital, Hallmark Health System
3. Mortality reported for patients still alive, recently readmitted to the hospital one month ago.

The inconsistencies and inaccuracies in this report raises serious questions as to the data being posted on a public website by the Department of Health and Human Services.

Hallmark Health System – Melrose-Wakefield Hospital

Review of reported cases revealed:

1. Duplicate data in Cardiac Category;
2. AMI and AMI Without Transfers represent the exact same patients; there has been not attempt to accurately capture this activity.
3. Mortality reported for patients still alive, recently readmitted to the hospital one month ago.

The inconsistencies and inaccuracies in this report raises serious questions as to the data being posted on a public website by the Department of Health and Human Services.

Heywood Hospital

There appears to be a discrepancy for some of the measures.

Lahey Clinic

Lahey Clinic is an academic medical center, physician group practice, and tertiary care hospital serving primarily eastern Massachusetts, and southern Maine, New Hampshire, and Vermont. Lahey Clinic is also a regional trauma center and recognized stroke center of excellence. For years we have provided efficient, safe, high quality care to men and women in need of the most advanced medical treatments and procedures for complex health problems. Lahey Clinic invests in advanced medical technologies to ensure that we remain a regional leader in complex specialty care. As an academic medical center, Lahey physicians typically treat a broad spectrum of patients, including those with very complex conditions. As such, Lahey Clinic should be compared to other Massachusetts teaching hospitals.

Massachusetts General Hospital

The physicians, nurses, and staff at Massachusetts General Hospital are very proud of the care that we provide. The MGH team is working hard to care for patients, train doctors and nurses, and conduct research on new drugs, technologies and treatments, all of which are important parts of our mission and all of which contribute to the superb quality of care we deliver.

While we are pleased that the state has developed a website designed to help patients and their families learn more about the quality of care in Massachusetts Hospitals, we would like to draw the readers' attention to the fact that we feel two of indicators displayed on this site should be viewed with some caution. Quality has many dimensions and some aspects of quality are difficult to measure or at least difficult to measure accurately.

We would strongly suggest that you look at the death rates (mortality rates) and cost calculations with the following comments in mind.

Most of the mortality rates presented in this report are calculated using a method developed by a government agency for hospitals to use as a screening tool. This method was not developed to provide

valid comparisons of mortality rates across hospitals. The rates are calculated using billing data that simply do not capture all aspects of quality. The national government abandoned using mortality rates to compare hospitals years ago. We feel it is a mistake to present the information in this way now, particularly in light of the history, and because we are working on better, more accurate ways to calculate mortality rates. For example, the Coronary Artery Bypass Graft (CABG) mortality rates presented in this report *are* calculated using a methodology that uses clinical information gathered from charts, reviewed by nurses and carefully adjusted for differences in populations. We think this method is a much more accurate and valid way to compare mortality rates across hospitals.

We are concerned that mortality rates posted for the *other* procedures and diagnoses may be inaccurate and misleading. This might steer patients towards or away from hospitals inappropriately. We have made our thoughts about this clear to the state.

The other measure that bears mention is cost. The cost comparisons among hospitals in this report do not take into account certain factors affecting the cost of care among hospitals:

- Costs of Special Missions: Certain hospitals incur additional costs related to their societal missions of training physicians and other health professionals; devoting relatively large percentages of their care to indigent patients, and providing other substantial benefits to their communities.
- Severity and Complexity of Illness: Cost differences among hospitals may also be the result of differences in the average severity and complexity of illness of patients with a particular condition or who undergo a particular procedure. For example, patients with more complex cases of congestive heart failure are more likely to seek care at teaching hospitals. Such patients require more intensive nursing care, more diagnostic tests and other resources.

These cost differences are formally recognized by Medicare, Massachusetts Medicaid and other payers in their determination of payment rates. Absent these adjustments, the cost of care among hospitals in this report may not be completely comparable. Readers are advised to consider this before drawing conclusions regarding the relative cost of care among hospitals.

With those caveats, we are pleased that the state has joined a number of other states in developing an important resource for its citizens and visitors and we look forward to continuing to work with the state to make this a valuable tool for you.

Morton Hospital and Medical Center

Morton Hospital and Medical Center report looks good. Thank you.

Nantucket Cottage Hospital

Nantucket Cottage Hospital is a full service, acute care facility with 19 licensed beds, and is accredited by the JCAHO as a Critical Access Hospital (sole, rural provider). The hospital has 14 Medical/Surgical beds, 1 ICU bed, 4 LDRP beds, and a 6 bed full time Emergency Department. The focus of care is on community needs which we address through our Inpatient, Outpatient, Home Care, and Hospice departments. Primary Medical coverage is provided by 5 full time MD's, while various specialties are covered by over 50 visiting consultants. Nantucket's geographic isolation, 27 miles from the Cape Cod mainland, offers special problems related to weather and access to Tertiary Care Centers. Transfer agreements with these centers provide care for patients needing cardiac care/surgery, neurosurgery, complicated bowel surgery, and Trauma care, to name a few.

Nashoba Valley Medical Center

Nashoba Valley Medical Center is pleased to be a part of the state-wide comparative website. We have evaluated our data and found some discrepancies, noted below. We are pleased that our risk adjustment rate for the measured indicators are all well below the average and that both cost and mortality are as expected for the indicators.

For further information on other hospital-specific quality data, please go to our website, www.nashobamed.com and click on Hospital Quality Data.

Newton-Wellesley Hospital

Costs: There are factors affecting costs, which are recognized by Medicare, Massachusetts Medicaid and other payers in their reimbursement rates, that this proposal does not take into account. These include the costs of a mission-driven organization, such as Newton-Wellesley Hospital that is dedicated to teaching health care professionals of the future, and the severity and complexity of illness within certain populations. The mission-driven costs relate to training of physicians, nurses and other health professionals, serving large populations of the elderly and providing public education, linkages to other civic organizations and strong community leadership in an era of growing concerns about disaster preparedness. Hospitals that have multiple nursing homes in close proximity have an older and more medically complex population seeking assistance.

As a result of these factors, the cost comparison in this report may be misleading and not reflect the actual contextual circumstances of the hospital.

For all indicators: The measures that are proposed herein for comparisons were developed by the Agency for Healthcare Research and Quality (AHRQ) with the intention to be used to facilitate internal performance improvement. The results are not adequately adjusted for patient acuity.
AHRQ did not intend for these measures to be used to compare hospital quality. While Newton-Wellesley Hospital fares well with these measures, we would not recommend them as the best available means to look at comparative hospital quality. Other national organizations are developing clinically meaningful and reliable quality measures that are an improvement in the effort to assess hospital quality.

For OB indicators: Of all the indicators listed, NWH feels that the obstetrical indicators in particular do not reflect hospital quality. In addition, we know of no precedence for the use of these measures to assess quality. We believe that the patient's history and personal characteristics along with consultation with her provider will result in the best evaluation of the risks and benefits of the alternate routes of delivery. These individual characteristics and complexities do not allow the data, as presented, to be standardized enough for use as a comparison of quality across hospitals.

Recommendation: Hospitals are already collecting, reporting and working to improve an evidence-based set of measures that are stable and better reflect key aspects of hospital quality. These include those promoted by Leapfrog, the National Hospital Quality Measures (JCAHO) and Massachusetts DPH Stroke efforts. The Centers for Medicare and Medicaid Services (CMS) is teaming up with JCAHO to coordinate the focus of their measurements.
We recommend the Commonwealth use better tested, validated and reliable hospital quality measures that are increasingly available to the public. We believe that the reliance on discharge-abstract data, known as "administrative data", are inadequate measures of clinical quality.

Noble Hospital

Community hospital practice in several conditions is improving rapidly and is expected to be better in 2005.

North Shore Medical Center – Salem Hospital

The Agency of Healthcare Research and Quality (AHRQ) developed these measures in 2003 with the intention that hospitals use this information to facilitate quality improvement initiatives within their facilities; they were not intended to evaluate or compare hospitals. NSMC - Salem Hospital applauds the efforts of AHRQ but cautions that the results are not adjusted adequately for the acuity of our patients, and results for NSMC - Salem Hospital are therefore not comparable to the results of other Massachusetts hospitals listed on this website. NSMC - Salem Hospital encourages patients to evaluate many factors when selecting the hospital for their care; your doctor's recommendation, word of mouth from friends and family, and your own prior experiences of care should supplement the many sources of quality data available on the world wide web.

The cost comparisons among hospitals in this report do not take into account certain factors affecting the cost of care. Specifically, cost differences among hospitals may be the result of differences in the average severity and complexity of illness of patients within an indicator. For example, patients with more severe or complex cases of congestive heart failure (CHF) are more likely to seek care at teaching hospitals because of their teaching and research missions. Such patients require more intensive nursing care, more diagnostic tests and other resources. These cost differences are formally recognized by Medicare, Massachusetts Medicaid and other payers in their determination of payment rates. Absent these adjustments, the cost of care among hospitals in this report may not be completely comparable. Users of this information are advised to consider this before drawing conclusions regarding the relative cost of care among hospitals.

North Shore Medical Center – Union Hospital

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Quincy Hospital

Quincy Medical Center is committed to providing the highest quality in each and every patient care experience. Our mission is clear to treat our patients with dignity and respect while giving excellent clinical care. Quality measures are monitored closely within the organization. Overall mortality measures are just one component of a broader quality scorecard that is tracked by senior leadership.

While the methodology of using billing data to cull out quality outcomes is not optimal, the data highlights our reality; namely that our patient demographic is primarily elderly with complex medical needs. We have recognized the fact that our patients may be better served in their last days with more palliative, rather than intensive, care. To this end, Quincy Medical Center has established and is in the process of implementing a Palliative Care Program.

Through enrollment in the national initiative of **IHI 100,000 lives campaign**, Quincy Medical Center is carefully monitoring the overall mortality rates and is pleased to note that this indicator is in a downward trend for the past three (3) quarters.

Saint Anne's Hospital

As requested members of the Caritas Christi Healthcare System have reviewed the materials submitted to our hospitals in the August 12th communication from EOHHS specific to the website release of hospital quality and cost data. We appreciate the opportunity to comment.

Most importantly, we support the intended activities of EOHHS to launch a public website to report comparative quality and cost data of acute care hospitals. This is indeed aligned with federal mandates to better inform the public of important activities of their local hospitals so as to provide the consumer with information to make an educated decision in selecting their healthcare as well as provide an incentive to the healthcare community to improve care. We do however have some concern with the information provided for possible publication and want to ensure the accuracy of this information before it is publicly posted. We also feel it is important all stakeholders are in agreement with selection of quality measure sets that will support the intention of the informational website.

In order to review the reported quality and utilization data, we asked members of our information technology department to provide individual hospital reports of the twelve selected indicators for FY 2003 (October 1, 2002 thru September 30, 2003). We abstracted the information from the hospital discharge data using the exact parameters provided. As you are already aware, craniotomy data did not match at all. For most cases, number of deaths matched our reports except for Caritas Holy Family Medical Center Hospital hip replacement. Zero deaths are noted on our report whereas two (2) deaths are identified on the DHCFP report. All other denominators do not match as well as we note higher case numbers than reported. Obstetrical data for all six hospitals is a total mismatch and although we have been working with DHCFP, we still cannot account for the disparity. Validation of this information should be a priority.

Secondly, we have concern with the use of AHRQ data to be the only indicator for quality. As noted on the AHRQ website, the access to AHRQ complication data should be used as a " *screening tool for hospital administrators to launch investigations into reasons for potential problems".* Administrative data continues to have limitations due to variability in coding, ambiguity in identification of condition pre-existence prior to hospital admission as well as limitations to availability of specific ICD-9-CM codes for all conditions. Although we review this data often, we note marked inaccuracies in acknowledging true issues with quality. For instance, Caritas St. Elizabeth's Medical Center reviews AHRQ data on a monthly basis. Post-operative/procedure pneumonias are reviewed. On average, we note 1 out of 3 cases actually meet the definition of pneumonia following surgical/procedural intervention, the others represent patients who arrive in the Emergency Department with suspect pneumonia, chest pain, have a cardiac intervention the next day. Of course these patients are additionally treated for the presenting pneumonia. The pneumonia did not follow the procedure but instead was also a condition on admission. As to using risk-adjusted mortality as an indicator of care, we remind you that the APR-DRG model for risk adjustment for mortality does not take into consideration transfer status nor DNR status, again, two important factors which impact patient's risk for mortality on admission to a hospital.

Thirdly, we wonder why obstetrical utilization was considered as a valid area to report quality? There has been much controversy over the last few years specific to
c-section rates and VBAC rates. At this point, we cannot say a high VBAC rate or high C-section rate is good or bad if not compared with obstetrical complication rates.

In review of the cost methodology, we commend EOHHS in its attempt to utilize the DHCFP-403 cost reports to determine patient level costs, we are concerned about the limitations that exist in the use of this data, the methodology used to determine "price", and the most relevant missing information to the consumer, their costs.

Applying average cost-to-charge ratios to patient specific charge data does not account for any case mix acuity differences between patients, which is the true driver of patient costs. One belief is that the increased utilization of ancillary services would lead to higher imputed costs, but it does not accurately capture the differences that exist at the core level of the Room and Board Charge. Given that all patients received the same R&B charge based upon the venue of their care, Medical/Surgery, ICU, CCU, there is no accounting for the real diagnosis-driven staffing and resource level differences that occur in caring for patients. Two patients within the ICU will be charged the same for each day of care, yet one may require 1-1 staffing, while the other does not. Simple averages do not accurately reflect the differences incurred.

By using applying the ratio of total patient revenues to total patient costs in an attempt to determine the "price level", the methodology may overstate the price, as certain revenues such as capitated premiums would be included in the revenues, but for services not provided within the hospital are not in the costs. Federal and State disproportionate hospital payments are also included in total patient revenues, which may not be germane to the "price level". The methodology starts with the assumption that hospitals

receive the same ratio of “price” by venue, inpatient and outpatient, and by the diagnosis that the data is reporting. This simply is not the case. There are wide variations in the both the inpatient and outpatient methodologies that payers employ in reimbursing hospitals from DRG-based systems, to per diems, to payment on account factors, to fee schedules. Furthermore, even within a methodology there may be further variation by specific diagnosis or disease entity, e.g. case rates for cardiac or surgical services. Clearly more discussion is warranted on this issue.

Beyond the mortality and morbidity issues, it would seem that the most useful information for the consumer is what their costs for care is. Given that Medicare and Medicaid represent over 50% of the total discharges in the base year data that EOHHS is using, the consumers’ costs is highly variable, as for these populations it was either zero or no more than $775 for the calendar year. We would encourage EOHHS to engage in much more discussion between payers and providers on refinement of this important element of comparison.

Again, we thank you for the opportunity to discuss the materials provided before they are publicly available. We hope this information will help you to assess the opportunity we both share to provide comparative quality and cost data to consumers provided the information is accurate, comprehensive and representative of information the consumer can assess with confidence to make an educated decision.

Saints Memorial Medical Center

Several of the data sets contain serious errors (data abstraction) and does not accurately reflect the expertise of our hospital and our physician staff.

The cost amounts could not be verified due to insufficient knowledge of the methodology. Also, the term cost is incorrect. The DHC FP is trying to arrive at a reimbursement per indicator, not a cost per indicator.

South Shore Hospital

South Shore Hospital is a charitable, not-for-profit, tax-exempt, regional provider of acute, outpatient, home health, and hospice care for the 600,000 residents of Southeastern Massachusetts. Please visit www.southshorehospital.org for more information.

Cardiac Care. With cardiac disease as the leading cause of death in our region, all "matters of the heart" remain a priority for South Shore Hospital. Our comprehensive cardiology program includes:

- 22 board-certified cardiologists
- A registered nursing staff with cardiology expertise
- An emergency department with a chest pain evaluation unit
- A cardiac catheterization unit equipped and staffed for primary angioplasty, peripheral vascular catheterization, and pacemaker implants
- A dedicated cardiac care unit
- A large telemetry inpatient nursing care unit
- Comprehensive cardiac testing services, including treadmill testing, nuclear cardiology, stress echocardiograms, Holter monitoring and cardiac electrophysiology testing
- A congestive heart failure clinic
- Dozens of early detection and prevention programs
- A four-phase cardiac rehabilitation program
- A home health cardiac team managed by a cardiac nurse specialist
- A cardiac support group which meets monthly

South Shore Hospital's cardiac catheterization laboratory is among the busiest in Massachusetts. For primary angioplasty patients, the so-called "door to dilation time" (between the patient's arrival in the cath lab until blood flow is restored to the blocked coronary artery) at South Shore Hospital is considerably less than the national average. Further, the in-hospital mortality of those patients is also less than the national average.

Our cardiac electrophysiology program treats patients with life-threatening heart arrhythmias. Treatment includes cardiac ablations and defibrillator implantations, procedures for which patients have traditionally traveled out of the region to receive.

Stroke Care. South Shore Hospital is among the first Massachusetts hospitals to receive state Department of Public Health (DPH) designation as a provider of primary stroke service, meeting requirements to provide emergency diagnostic and therapeutic services to patients with acute stroke symptoms 24 hours a day, seven days a week.

DPH surveyors evaluated South Shore Hospital's systems for communicating with EMS personnel, its ability to provide diagnostic CT scan exams within accepted time targets, its ability to perform and evaluate chest x-rays, EKGs, and lab tests within accepted time targets, and the around-the-clock availability of neurologists.

When a South Shore Hospital physician initiates a "Code Stroke," multiple hospital clinicians are automatically mobilized to speed evaluation, diagnosis and treatment options for patients who may be experiencing a stroke.

Obstetrics/Gynecology. South Shore Hospital's comprehensive OB-GYN services feature:

- A choice of community-based maternity health care providers who are affiliated with South Shore Hospital, including more than 40 OB/GYNs, 14 certified nurse midwives, and five family practitioners.
- New maternity center, where each mother gives birth and recovers in a private birthing room and then moves to a new, private, post-partum room, where our nursing staff is dedicated to providing the highest standard of family-centered care.
- Neonatal Intensive Care to care for ill or premature infants, staffed 24 hours by onsite, board-certified neonatologists from Children's Hospital, Boston.
- A reproductive medicine program, offered in association with Brigham and Women's Hospital, for women with fertility complications.
- A maternal-fetal medicine program to support women experiencing high-risk pregnancies.
- Round-the-clock access to board-certified anesthesiologists and pain management services.
- Certified lactation specialists to offer teaching and support for breastfeeding mothers.
- Availability of home health services to ease mother's and newborn's transitions home.

Surgical care. South Shore Hospital's surgical team includes 150 board-certified surgeons, 22 board-certified anesthesiologists, 25 certified registered nurse anesthetists, and more than 245 nurses, technicians, and other perioperative staff members who work collaboratively on behalf of patients — before, during, and following each operation. Together, the team performs approximately 20,000 inpatient and outpatient surgeries each year.

The surgical center features 14 operating suites, outfitted with the latest equipment and technology to assist surgeons in performing all types of procedures — from highly complex vascular surgery to more routine day surgery procedures.

South Shore Hospital's surgical program is supported by a comprehensive team of clinical and support services, including:

- Medical intensivists, physicians who are certified in the care of critically ill and injured patients.
- Nutrition and food services, to meet unique nutritional needs.
- Respiratory therapy, to enhance breathing and respiratory function.
- Rehabilitation services, to rebuild strength and coordination following surgery.

South Shore Hospital scored higher than most hospitals in the country during its 2003 Joint Commission on Accreditation of Healthcare Organizations survey, earning the agency's Gold Seal of Approval. The Joint Commission is the nation's leading health care accrediting agency. Its surveyors have exhaustively reviewed every aspect of South Shore Hospital — from patient care to facilities, clinical

staff to management. South Shore Hospital's acute, outpatient, home health and hospice service are each accredited with full standards compliance, the Joint Commission's highest possible accreditation.

South Shore Hospital retains Press-Ganey Associates — the nation's largest independent patient satisfaction monitoring organization — to measure how satisfied patients are with our care. South Shore Hospital routinely scores above state, regional, and national averages in overall patient satisfaction. Among the questions we ask patients on Press-Ganey satisfaction surveys is whether they would recommend South Shore Hospital to a family member or friend — a strong vote of confidence in our quality and services. Typically, nine in ten of our acute and home health care patients report that they would recommend South Shore Hospital.

Quality health care necessitates the availability of qualified physicians, nurses, clinicians and support staff who are available to capably address our patients' medical needs and critical care needs. Our medical staff members are board-certified or board-eligible in their medical specialties. No other hospital in the region has such a large, experienced, and diversified medical staff. In addition, we employ more registered nurses than any hospital in the region because we have refused to allow nursing care to be provided by unlicensed caregivers.

South Shore Hospital partners with leading academic medical centers to bring their physician experts to our region. Examples include:

- Neonatal intensive care, pediatric emergency, inpatient pediatric services, and outpatient pediatric clinics, provided in association with physicians from Children's Hospital Boston.
- Breast Care Center, cardiology, reproductive endocrinology, gynecological oncology, urogynecology, and a surgical residency program, provided in association with physicians from Brigham & Women's Hospital.
- Select clinical cancer trials, offered in association with Dana-Farber/Partners Cancer Care.

South Shore Hospital demonstrates its commitment to the critical care needs of our patients through:

- 24/7 on-site medical coverage in our critical care units by board-certified anesthesiologists.
- 24/7 on-site medical coverage for obstetrical patients by board-certified obstetricians/gynecologists.
- Internal medicine Hospitalist program provides optional in-house coverage for our hospitalized patients 24 hours a day, seven days a week.
- 24-bed MICU, SICU, and CCU staffed by board-certified anesthesiology intensivists 24 hours a day.
- A pediatric emergency program staffed by board-certified pediatric emergency physicians.
- An inpatient pediatric unit organized and facilitated by board-certified pediatricians affiliated with Children's Hospital, Boston.
- Full-time clinical chairs of surgery, medicine, obstetrics, and emergency care (typically only found in academic medical centers).

Please call Dr. Marvin (Spike) Lipschutz at (781) 340-8996 for more information about South Shore Hospital's commitment to quality and safety.

Southcoast Hospitals Group

I have had extensive conversations with DHCFP regarding the data, and appreciate their assistance on this matter. In general, Southcoast has several concerns with the cost data and the assignment of "$" signs.

1. Southcoast is concerned about the timeliness of the data. It has been explained to us, that it is 2001 department level ratio of cost to charges (RCCs) applied to 2002 patient charges. Since that time, significant changes have occurred at Southcoast that may not reflect current practices. For example, an internal team has been working on reducing the length of stay for pneumonia. This would reduce

the charges on the patient's claims and ultimately the cost. The State should obtain 2004 data, which has been available for some time, and provide hospitals with ample time for review.

2. Use of an overall department RCC may not be correct for the single procedure used in the department. For example, when Southcoast used our internal cost accounting system to replicate your data, our costs were significantly different for AMI, CHF and Pneumonia. The cost difference ranged from $724 per case to $2,129 per case.

3. The report lists "Cost" in one of the columns, but I would note that your actual calculations are really trying to replicate "Net Revenue" or "Payment" to the Hospital. The calculation takes cost per patient (derived via RCC times charges) and applies a gross-up, which was based on the ratio of Net Patient Service Revenue to Cost. If the true intention of this calculation were to approximate the cost to a patient or payor, then I would disagree with the methodology. For individuals with insurance, they would be responsible for the applicable deductible, co-pay, or coinsurance based on their member benefit design package. Medicare patients are only responsible for the inpatient deductible, which is the same at all hospitals nationwide. For the payor, this number can be significantly different for their particular contract. For self-pay patients, they may qualify for full or partial free care, or a sliding scale discount.

4. Most of the inpatient cases that are highlighted have high utilization in the Medicare population. For example: Hip Replacements, AMI, CHF, Stroke, and Pneumonia. The report attempts to replicate the payment a hospital receives. However, most of the hospitals would receive nearly the same payment from Medicare with the exception of their wage index, disproportionate share adjustment and teaching status. Therefore, saying that Southcoast should be "$$$" or very costly, does not agree with the actual "Cost to Medicare" or "Payment from Medicare". The methodology does not appear to correctly reflect its goal.

5. Each year, the Division of Health Care Finance and Policy (DHCFP) issues the annual Request for Proposal contract. DHCFP worksheets have been provided that lists the average cost per discharge of each hospital in the State. The data continually shows Southcoast as a low cost provider in the State. It therefore does not make sense, that on these reports, Southcoast is listed as a very expensive provider in almost 60% of all services measured. In addition, for Medicaid patients, the State reimburses the Hospital at only 68% of its inpatient costs, so it is highly unlikely that Southcoast should be listed as very expensive. The State should seriously consider whether this kind of information will cause Medicaid recipients to erroneously move their care from a low cost provider (and paid below cost) to a higher paid Standard Payment Amount per Discharge (SPAD) provider.

6. It is hoped that in the final format, that more information is given to describe the various data elements. For example, on the report that we received, there were no definitions for: GT, LT, Lower Conf. Int., Upper Conf. Int., Risk-adj rate, or Quartile Range. There was also no descriptions used to define the how the numbers were calculated, and why they were important. Hospitals in particular, were given an inadequate amount of information and time to determine whether the data was reasonable.

7. The type of individuals that may access this website, may be those that have a greater ability and ease to transfer their care from one community to another. By denoting that Southcoast is an expensive provider in so many of the categories, the State may in effect cause a shift by individuals (and their health insurance company) that help offset our disproportionate free care and Medicaid burden. Southcoast is seriously concerned that this data is erroneous, and may cause unintended harm to our institution.

Southcoast is available to assist with indicators that are important to assuring the availability and affordability of quality health care to residents of the Commonwealth. If you have any questions on this information, please contact me at 508-961-5067.

Sturdy Memorial Hospital

Mortality alone is not a good indicator of quality. We would prefer to see CMS quality indicators included as well.

In a community hospital, Do Not Resuscitate (DNR) status is highly correlated with mortality (see especially the AMI and pneumonia comments). When a DNR patient dies, we are following the patient's wish that we not apply extraordinary measures like mechanical ventilation just to keep him/her breathing when there is no hope of a return to quality life. Repeat: this is the patient's choice.

Winchester Hospital

Winchester Hospital approaches its efforts to improve patient safety, clinical quality and patient satisfaction extremely seriously. Each year our organization makes a hospital wide commitment to improve safety and satisfaction as part of annual goal setting process. Our ratings within the recent measures published by the Centers for Medicare and Medicaid (CMS) place among the highest rated hospitals in the country.

Although we support the public publishing of quality measures like those included in this web site and the information available on the CMS website, we encourage consumers to consider it as only one source of information. The data included in this web site shows Winchester Hospital to have mortality rates that are consistent with clinical expectations for the care provided and an estimated cost per procedure that is lower than many other hospitals in the State. It is, however, based on diagnosis and procedure coding and other information that is subject to variability in reporting and interpretation. The information presented was not originally developed for quality or financial comparisons among providers.

Winchester Hospital strongly believes that currently, the best way for a consumer to choose the best provider for their specific clinical situation is to have a detailed and open conversation with their physician, and to seek second opinions from other qualified providers if appropriate.

To learn more about Winchester Hospital and our services, please visit www.winchesterhospital.org.